PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICAL RECORD NUMBER: _____ **PHONE #:** _____

RELEASE FROM HOLYOKE MEDICAL CENTER: I authorize Holyoke Medical Center to release my health information to:

Name: _____

Address: _____

What to Release: *Dates of Service:* _____

Please include the following information:

- ☐ Abstract (Physician reports, Labs, X-rays, EKGs)
- ☐ Lab Reports
- ☐ X-ray Reports ☐ Films
- ☐ Cardiology/EKG/Neurology Reports
- ☐ Medical History & Physical Examination
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Pathology Reports ☐ Pathology Slides
- ☐ Speech & Hearing
- ☐ Work Connection (OHS - OHC - EHP)
- ☐ DOT Examination "Long Form"
- ☐ Behavioral Health
  - ☐ Inpt ☐ PHP/IOP ☐ Outpt ☐ Social Work & Assessment Team
- ☐ Other: _____

Purpose of Request: ☐ Patient Care ☐ Legal ☐ Personal ☐ Other: _____

RELEASE TO HOLYOKE MEDICAL CENTER: I authorize _____ to release my health information to:

Holyoke Medical Center, Attention Dept: _____ , 575 Beech Street, Holyoke, MA 01040

What to Release: *Dates of Service:* _____

Please include the following information:

- ☐ Abstract (Physician reports, Labs, X-rays, EKGs)
- ☐ Lab Reports
- ☐ X-ray Reports ☐ Films
- ☐ Cardiology/EKG/Neurology Reports
- ☐ Medical History & Physical Examination
- ☐ Other: _____
- ☐ Pathology Reports ☐ Pathology Slides
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Behavioral Health
  - ☐ Assessment ☐ Tx Plan/Progress ☐ D/C Summary

Purpose of Request: ☐ Patient Care ☐ Legal ☐ Personal ☐ Other: _____

RELEASE OF PRIVILEGED INFORMATION: If your medical record contains any of the following types of information it **will not** be released unless you check (✓) the type of information we may disclose:

☐ Psychiatric ☐ Alcohol and/or drug abuse ☐ Sexually transmitted diseases
☐ HIV / AIDS* (See below) ☐ Attendance / Participation in Psychiatric or Substance Abuse Program

****RELEASE OF HIV/AIDS INFORMATION:***

I hereby authorize release of my health information pertaining to HIV and/or AIDS related testing, diagnosis and/or treatment.
Signature: _____ *Date:* _____

INDIVIDUAL RIGHTS: I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Health Information Management Department at Holyoke Medical Center or must contact the party whom I had authorized to release the information, if other than Holyoke Medical Center.
- My right to revoke does not apply to information already released on the basis of this authorization.
- The privacy of my health records is protected under "HIPAA," 42 CFR, pts 160 & 164, and the privacy of any alcohol and/or drug treatment records are also protected under the Federal Confidentiality & Drug Abuse Records regulations, 42 CFR, pt 2.
- I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility of benefits.
- The information released on the basis of this authorization may be subject to redisclosure by the recipient.
- There may be a charge for providing copies of medical records.

Expiration Date: This authorization will expire in 180 days unless revoked or otherwise specified to be the following date, event or condition. _____

Signature: _____ ***Date:*** _____

<u>If not signed by patient, specify relationship</u>: ☐ Parent ☐ Next of Kin ☐ Legal Guardian/Designee

Holyoke Medical Center

AUTHORIZATION TO USE and DISCLOSE HEALTH INFORMATION